STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155336	A. BUILDING 01 B. WING	07/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DECATUR TOWNSHIP CARE AND REHABILITATION CENTER	4851 TINCHER ROAD INDIANAPOLIS, IN46221

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/18/11 Facility Number: 000229 Provider Number: 155336 AIM Number: 100266850 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Decatur Township Care and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has battery operated smoke	K0000	The Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Decatur Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	detection in all resident rooms. The facility has a capacity of 88 and had a census of 77 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/25/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 doors to the kitchen, a hazardous area, were self closing. This deficient practice could affect any resident, staff or visitor in the vicinity of the east dining room kitchen door. Findings include: Based on observation with the Administrator and the Maintenance	K0029	a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. The Maintenance Director repaired the door immediately and ensured its safety. Dietary staff will be reeducated on proper notification of repairs needed. In-service to be completed by 8/15/11. d. The Maintenance Director/Designee will monitor East	08/15/2011

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	Director during a tour of the facility from 1:05 p.m. to 3:40 p.m. on 07/18/11, the east dining room kitchen door is equipped with a self closing device but the door does not close and latch securely into the door frame as the top of the door is prevented from closing by striking the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the east dining room kitchen door is equipped with a self closing device but is prevented from closing by the door frame. 3.1-19(b)		dining room door for compliance weekly X2 for one week, then monthly X3.	
K0046 SS=C	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure emergency lighting was provided for 1 of 1 emergency generators. This deficient practice could affect all occupants in the facility including staff, visitors and residents. Findings include: Based on observation with the Administrator and the Maintenance	K0046	a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. On 7/20/11, the battery operated emergency lighting was replaced by Maintenance Director. Light still failed. Light bulbs replaced on 8/1/11. Electrician consulted and repair/consult to be completed 8/5/11. d. The Maintenance	08/15/2011

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	Director during a tour of the facility from 1:05 p.m. to 3:40 p.m. on 07/18/11, the battery operated emergency light located outside the facility at the emergency generator failed to illuminate when the test button was pressed four times. Based on interview at the time of observation, the Maintenance Director acknowledged the battery operated emergency light failed to illuminate when the test button was pressed. 3.1-19(b)		Director/Designee will monitor after repairs, system compliance weekly X1 for two weeks, then monthly X3.	
K0048 SS=C	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to ensure its written fire safety plan incorporated all the items outlined in LSC 19.7.2.2. in order to protect 77 of 77 residents. LSC 19.7.1.1 requires every nursing home to have in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire and for their evacuation to areas of refuge and for evacuation from the building when necessary. All employees shall be periodically instructed and kept	K0048	a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. On 8/4/11, Decatur Township Care and Rehabilitation Center implemented a plan of protection of residents, staff, and visitors to the activation of resident room battery operated smoke detectors and the extinguishment of fire. All staff to be in-serviced by 8/15/11. d. The Maintenance	08/15/2011

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	informed with respect to their duties under the plan. A copy of the plan shall be readily available. The provisions of LSC 19.7.1.2 to 19.7.2.3 inclusive shall apply. LSC 19.7.2.1 requires for health care occupancies, the proper protection of residents shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants, confinement of the effects of the fire by closing doors to isolate the fire area, and the execution of those evacuation duties as detailed in the facility's fire safety plan. LSC 19.7.2.2 states a written facility fire safety plan shall provide for: (a) Use of alarms, (b) Transmission of alarm to fire department, (c) Response to alarms, (d) Isolation of fire, (e) Evacuation of immediate area, (f) Evacuation of smoke compartment (g) Preparation of building for evacuation (h) Extinguishment of fire. This deficient practice affects all residents, staff and visitors. Findings include:		Director/Designee will monitor the policy and procedure will be placed in appropriate manuals and reviewed per policy.	

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	Based on review of the facility's written fire safety plan policies entitled "Fire Drill Checklist" and "Fire Drill Procedure" during record review from 9:40 a.m. to 12:00 p.m. on 07/18/11 with the Administrator and the Maintenance Director, each policy did not address staff response to the activation of resident room battery operated smoke detectors or the extinguishment of fire. Based on interview at the time of observation, the Administrator and the Maintenance Director stated the Fire Drill Checklist and the Fire Drill Procedure policies constitute the facility's written fire safety plan and acknowledged the fire safety plan does not include staff response to the activation of resident room battery operated smoke detectors or the extinguishment of fire. 3.1-19(b)			

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K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on the first shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Record of Drills" documentation with the Maintenance Director from 9:40 a.m. to 12:00 p.m. on 07/18/11, there is no documentation of a fire drill being conducted on the first shift in the third quarter in 2010. Based on interview at the time of record review, the Maintenance Director stated a fire drill was not conducted on the first shift of the third quarter of 2010 and acknowledged there is no documentation of a first shift third quarter fire drill available for review. 3.1-19(b)	K0050	a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. The Maintenance Director/Designee will be in-serviced on the proper documentation necessary for record of fire drill compliance by Administrator by 8/15/11. d. The Maintenance Director/Designee will monitor documentation compliance monthly for one quarter to assure drills are in compliance with regulation.	08/15/2011

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K0054 SS=E	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Based on record review and interview, the facility failed to ensure 5 of 41 smoke detectors which had failed sensitivity testing had been repaired or replaced following required sensitivity testing. LSC 9.6.1.3 indicates provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, The National Fire Alarm Code. NFPA 72, at 7-3.2 requires testing in accordance with Table 7-3.2, Testing Frequencies. Table 7-3.2.15(i) refers to 7-3.2.1 which requires Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector had remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in	K0054	a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. The Maintenance Director/Designee will repair/replace all deficient smoke detectors by 8/15/11. d. The Maintenance Director/Designee will monitor smoke detectors will continue to monitor annually. Any future failed sensitivity detectors will be replaced within 7 days.	08/15/2011

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	areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. NFPA 72 at 7-1.1.2 states system defects and malfunctions shall be corrected. This deficient practice affects all residents in the facility. Findings include:			

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	Based on review of SafeCare's "Sensitivity Test and Inspection Report" documentation dated 06/16/11 with the Maintenance Director from 9:40 a.m. to 12:00 p.m. on 07/18/11, the following smoke detectors and their location were listed as "Fail": (1) O/S 37. (2) O/S 42. (3) O/S 46. (4) East Resident Lounge. (5) East Nurse's Station. Based on interview at the time of record review, the Maintenance Director acknowledged these five smoke detectors did not pass the most recent sensitivity test and these five smoke detectors have not been repaired or replaced. 3.1-19(b)			
K0064 SS=E	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 3 of 15 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10,	K0064	a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. Due to the passage of time, Maintenance Director cannot inspect portable fire extinguishers for previous month. Maintenance	08/15/2011

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	Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could effect any staff, resident or visitor in the vicinity of the laundry room, the southwest nurses' station and the east nurses' station. Findings include: Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 1:05 p.m. to 3:40 p.m. on 07/18/11, the inspection tags for the fire extinguishers located in the laundry room and the southwest and east nurse's station each indicated the annual fire extinguisher inspection was conducted in March 2011 but the tags lacked documentation of a monthly inspection for the month of June 2011. Based on interview at the time of observation, the Maintenance Director acknowledged the monthly inspection for the fire extinguisher located in the laundry room and in the southwest and east nurses' station was not conducted for June		Director has implemented new form that identifies fire extinguishers at each location in facility. d. The Maintenance Director will monitor the inspection of the facility's fire extinguishers ongoing monthly per regulation.	

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	2011. 3.1-19(b)			
K0066 SS=E	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observations and interview, the facility failed to ensure cigarette butts were deposited into noncombustible containers for 1 of 2 areas where smoking was permitted. This deficient practice could affect any residents including visitors and staff if they were utilizing the resident outdoor smoking area shed near the southeast exit door of the facility.	K0066	a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. The Maintenance Director will in-service staff regarding proper disposing of cigarette butts by 8/15/11. d. The Maintenance Director will monitor permitted smoking areas daily X5 for 2weeks, then 2X weekly	08/15/2011

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	Findings include: Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 1:05 p.m. to 3:40 p.m. on 07/18/11, the enclosed outdoor smoking area shed which is outside of the facility near the southeast exit and is constructed of wood measuring ten feet by twelve feet had more than thirty five cigarette butts strewn about the flooring of the wooden access ramp to the smoking area shed. Two noncombustible containers for cigarette butts were provided inside the resident smoking area shed and no cigarette butts were observed on the flooring of the shed. Based on interview at the time of observation, the Maintenance Director acknowledged the facility supplies noncombustible containers for use in the resident outdoor smoking area shed but cigarette butts were extinguished on the wooden access ramp to the resident smoking area shed. 3.1-19(b)		for two weeks, then monthly X3.	

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K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where oxygen transferring takes place was provided with continuous mechanical ventilation. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room by the southwest nurses' station. Finding include: Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 1:05 p.m. to 3:40 p.m. on 07/18/11, the oxygen storage and transfilling room by the southwest nurses' station is provided with two mechanical ventilation systems one of which can be turned off with the light switch for the room and the second	K0143	a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. The Maintenance Director repaired continuous mechanical ventilation to the required areas. d. The Maintenance Director will monitor continuous ventilation weekly X2, then monthly X3.	08/15/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	is a continuous mechanical system which was not operating. Based on interview at the time of observation, the Maintenance Director acknowledged the continuous mechanical ventilation system was not in operation for the oxygen storage and transfilling room by the southwest nurses' station. 3.1-19(b)			
K0144 SS=C	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. NFPA 110, 7-1 states NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines,	K0144	a. No residents, staff, or visitors were adversely affected by this deficient practice. b. Residents, staff, and visitors had the potential to be affected by this deficient practice. c. The Maintenance Director/Designee installed a remote manual stop to the emergency generator. d. The Maintenance Director will monitor compliance of the manual stop monthly X3.	08/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155336	A. BUILDING 01 B. WING	07/18/2011

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	contains mandatory requirements for emergency generators and shall be considered part of the requirements of this standard. NFPA 37, 8-2.2(c) requires emergency generators of 100 horsepower of more have provisions for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 1:05 p.m. to 3:40 p.m. on 07/18/11, a remote shut off device was not found for the 155 kilowatt diesel fired emergency generator. Based on interview at the time of observation, the Maintenance Director stated the emergency generator was installed in 1985 and acknowledged the emergency generator is more than 100 horsepower and does not have a remote emergency shut off. 3.1-19(b)			

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